

Reservoir High School
Music Department Annual Spring Trip
Over-the-Counter Medication Form

STUDENT NAME: _____ GRADE: _____

DATE OF BIRTH: _____

PHYSICIAN NAME: _____

PHYSICIAN CONTACT INFORMATION: _____

IN THE EVENT OF PAIN _____ MAY BE
ADMINISTERED.

IN THE EVENT OF STOMACH ACHE _____ MAY BE
ADMINISTERED.

IN EVENT OF ALLERGIC REACTION _____ MAY BE
ADMINISTERED.

PHYSICIAN SIGNATURE: _____

PARENT SIGNATURE: _____

NOTE TO PARENTS AND PHYSICIANS:

This form is intended to give the trip-nurse permission to administer over-the-counter medications to the student in the event of medical necessity.